Program Requirements for Residency Training in Psychiatry

I. Introduction

A. Scope of Education

An approved residency program in psychiatry must provide an educational experience designed to ensure that its graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders as well as other common medical and neurological disorders that relate to the practice of psychiatry. While residents cannot be expected to achieve the highest possible degree of expertise in all of the diagnostic and treatment procedures used in psychiatry in 4 years of training, those individuals who satisfactorily complete residency programs in psychiatry must be competent to render effective professional care to patients. Furthermore, they must have a keen awareness of their own strengths and limitations and of the necessity for continuing their own professional development. The didactic and clinical program must be of sufficient breadth and depth to provide residents with a thorough and well-balanced presentation of psychological, sociocultural, and neurobiological observations and theories and knowledge of major diagnostic and therapeutic procedures in the field of psychiatry. It must also provide the education and training necessary to understand the major psychiatric literature, to evaluate the reliability and validity of scientific studies, and to appropriately incorporate new knowledge into the practice of medicine.

Programs are expected to operate in accordance with the "AMA Principles of Ethics with Special Annotations for Psychiatry" and to ensure that the application and teaching of these principles are an integral part of the educational process.

B. Duration and Scope of Education

1. Admission Requirements

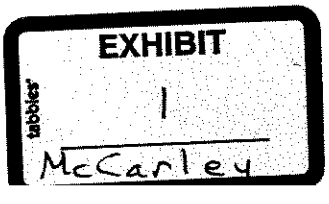
Physicians may enter psychiatry programs at either the first-year or second-year postgraduate level. Physicians may enter programs at the second-year postgraduate level only after successful completion of one of the following:

a. A clinical year of training in an Accreditation Council of Graduate Medical Education (ACGME)-accredited program in internal medicine, family practice, or pediatrics

b. An ACGME-accredited transitional year program

c. One year of an ACGME-accredited residency in a clinical specialty requiring comprehensive and continuous patient care

d. For physicians entering at the PG-2 level, the PG-1 year may be credited toward the 48-month requirement



2. Length of the Program

   a. A complete psychiatry residency is 48 months. Twelve of those months may be spent in an ACGME-approved child and adolescent psychiatry residency. Accreditation by the ACGME is required for all years of the training program. Programs may not permit residents to use vacation time or other benefit time to advance the date of graduation from training. Although residency is best completed on a full-time basis, part-time training at no less than half time is permissible to accommodate residents with personal commitments (eg, child care).

   b. Any program that alters the length of training beyond these minimum requirements must present a clear educational rationale consonant with the Program Requirements and objectives for residency training. The program director must obtain the approval of the sponsoring institution and the Residency Review Committee (RRC) prior to implementation and at each subsequent review of the program.

   c. Prior to entry into the program, each resident must be notified in writing of the required length of training for which the program is accredited. The required length of training for a particular resident may not be changed without mutual agreement during his/her program, unless there is a break in his/her training or the resident requires remedial training.

   d. Programs should meet all of the Program Requirements of Residency Training in Psychiatry. Under rare and unusual circumstances, programs of either 1 year's or 2 years' duration may be approved, even though they do not meet all of the above requirements for psychiatry. Such 1- or 2- year programs will be approved only if they provide some highly specialized educational and/or research programs. Also, such programs will be approved only if they ensure that residents will complete the didactic and clinical requirements outlined in the Program Requirements.

3. Program Format by Year of Training

   a. First year of training

      A psychiatric first postgraduate year must include at least 4 months in internal medicine, family practice, and/or pediatrics. This training must be in a clinical setting that provides comprehensive and continuous patient care.

      1. Neurology rotations may not be used to fulfill this 4-month requirement.

      2. One month, but no more, of this requirement can be fulfilled by an emergency medicine or intensive care rotation, as long as the experience is predominantly with medical evaluation and treatment as opposed to surgical procedures.

      3. A psychiatric first postgraduate year should not include more than 6 months in psychiatry and must not include more than 8 months in psychiatry.

      4. A minimum of 2 months of neurology, or its full-time equivalent on a part-time basis, is required prior to completion of training. It is highly desirable that this experience occur during a psychiatric first postgraduate year, and it may include a maximum of 1 month of supervised inpatient or outpatient child neurology.

      5. The program director of the Department of Psychiatry must maintain contact with residents during the first postgraduate year while they are on services other than psychiatry.

   b. The second through fourth years of training

      Although some of the training described below may be offered in the first postgraduate year, all must be completed prior to graduation from the program.

      1. The program must have an explicitly described educational curriculum covering the broad spectrum of clinical psychiatry as outlined in V.B.1.a-o.

      2. The formal didactic instruction must include regularly scheduled lectures, teaching rounds, seminars, clinical conferences, and required reading assignments covering the topics identified in Section V.

3. There must be an educationally sound balance among time spent in direct patient care, clinical and didactic teaching, and supervision. Formal educational activity shall have high priority in the allotment of the resident's time and energies. Service needs and clinical responsibilities must not prevent the resident from obtaining the requisite didactic educational activities and formal instruction.

4. Planned Educational Experiences. Each program must offer its residents planned and sufficient educational experiences. These educational experiences should include presentations based on a defined curriculum, journal review, administrative seminars and research methods. They may include but are not limited to problem-based learning, laboratories, and computer-based instruction, as well as joint conferences cosponsored with other disciplines. The program should ensure that residents are relieved of nonemergent clinical duties to attend these planned educational experiences. Although release from some off-service rotations may not be possible, the program should require that each resident participate in at least 70% of the planned psychiatry educational experiences offered (excluding vacations). Attendance must be monitored and documented.

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II. Institutional Organization

A. Sponsoring Organization

1. Programs should be conducted under the sponsorship of an institution that meets the Institutional Requirements that apply to residency programs in all specialties, as outlined in the Essentials of Accredited Residencies.

2. The administration of the sponsoring institution(s) should be understanding of and sympathetic to the attainment of educational goals and should evidence its willingness and ability to support these goals philosophically and financially. The latter includes a commitment by the institution and by the program that embraces appropriate compensation for faculty and residents, adequate offices and educational facilities, support services, and opportunities for research.

3. It is important that each affiliated institution demonstrate significant commitment to the overall program. The educational rationale for including each institution within the program must be stated. The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and didactic exercises. Geographic proximity will be one factor in evaluating program cohesion, continuity, and "critical mass". Affiliated training sites will be evaluated on the basis of whether they contribute to a well-integrated educational program with respect to both didactic and clinical experiences.

4. When there is a cooperative educational effort involving multiple institutions, the commitment of each institution in the program must be made explicit in an affiliation agreement with each institution that conforms to ACGME Institutional Requirements.

B. Selection and Appointment of Residents

1. The program director is responsible for maintaining a process for selecting resident physicians who are personally and professionally suited for training in psychiatry. It is highly desirable that each program have a residency selection committee to advise the program director.

2. The program must document the procedures used to select residents. Application records must contain complete information from medical schools and graduate medical education programs. A documented procedure must be in place for evaluating the credentials, clinical training experiences, past performance, and professional integrity of residents transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program. This procedure must include solicitation and documentation of relevant information from the training directors of the previous programs participated in by the transferring resident. This documentation must specify all clinical and didactic experiences for which the resident has been given credit. Those residents selected at the second postgraduate year or above must have satisfied the training objectives cited above for reaching that level of training.

3. The residency program director must accept only those applicants whose qualifications for residency include sufficient command of English to facilitate accurate, unimpeded communication

with patients and teachers.

4. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

5. The RRC will determine the size of the program's permanent resident complement by approving a range based on the program's clinical and academic resources.

6. To promote an educationally sound, intellectually stimulating atmosphere and effective graded responsibility, programs must maintain a critical mass of at least three residents at each level of training. Programs that fall below this prescribed critical mass will be reviewed, and if this deficiency is not corrected, they may be cited for noncompliance, except when the number of PG-4 residents is below critical mass owing to residents entering child and adolescent psychiatry training.

7. Programs in which the number of residents exceeds the resources of patient population, faculty, or facilities for adequate training will be found deficient on the basis of size.

8. Any permanent change in the number of approved positions requires prior approval by the RRC. [1] Prior approval is not required for temporary changes in resident numbers owing to makeup or remedial time for currently enrolled residents or to fill vacancies. Approval of permanent increases above the approved range of residents will require documentation that didactic and clinical training, including supervision, will not be compromised.

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III. Faculty Qualifications and Responsibilities

The program leadership and the teaching staff are responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation.

A. Chair of Psychiatry

The chair of psychiatry must be a physician and must either be certified by the American Board of Psychiatry and Neurology or judged by the Residency Review Committee to possess appropriate educational qualifications.

B. Program Director

There must be a single program director responsible for the program. Each residency program must be under the direction of an experienced, fully trained, and qualified psychiatrist whose major responsibility is to maintain an excellent educational program. The residency program director must possess the necessary administrative, teaching, and clinical skills and experience to conduct the program. Continuity of leadership over a period of years is important to the stability of a residency program. Frequent changes in leadership or long periods of temporary leadership usually have a negative effect on an educational program and may adversely affect the accreditation status of the program. The program director must

1. be licensed to practice medicine in the state where the institution that sponsors the program is located. (Certain federal programs are exempted.)

2. be either certified by the American Board of Psychiatry and Neurology or judged by the Residency Review Committee to possess appropriate qualifications.

3. have an appointment in good standing to the medical staff of an institution participating in the program.

4. devote at least one-half of his/her time to the administration and operation of the educational program, including didactic, supervisory, and clinical teaching activities. Programs with multiple institutions, many residents, and/or a large clinical population will require additional time.

C. Responsibilities of the Program Director

1. The program director must have appropriate authority to oversee and to organize the activities of the educational program. The responsibilities of this position should include but not be limited to the following:

    a. Resident appointments and assignments in accordance with institutional and departmental policies and procedures

    b. Supervision, direction, and administration of the educational activities

    c. Coordination of training in each geographically separate institution

    d. Selection and supervision of the teaching staff and other program personnel at each institution participating in the program.

    e. Supervision of residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.

    f. Regular evaluation of residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.

    g. Provision of a written final evaluation for each resident who completes the program, as specified in Sections VI.A.7 and VI.A.8.

    h. Preparation of a written statement outlining the educational goals of the program with respect to knowledge, skills, and other attributes of residents at each level of training and for each major rotation or other program assignment. This statement must be distributed to applicants, residents, and members of the teaching staff. It should be readily available for review.

    i. Provision of written information to applicants and residents regarding financial compensation, liability coverage, and the policies regarding vacations, sick leave, parental leave, and other special leaves.

    j. Implementation of fair procedures as established by the sponsoring institution regarding academic discipline and resident complaints or grievances.

    k. Monitoring resident stress, including physical or emotional conditions inhibiting performance or learning and drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.

    l. Maintenance of a permanent record of evaluation for each resident that is accessible to the resident and other authorized personnel. These will be made available on review of program.

    m. Preparation of an accurate statistical and narrative description of the program as requested by the RRC for Psychiatry.

    n. Written notification to the Executive Director of the RRC within 60 days of any major change in the program that may significantly alter the educational experience for the residents, including

        1. changes in leadership of the department or the program;

        2. changes in administrative structure, such as an alteration in the hierarchical status of the program/department within the institution; and

        3. changes in the resident complement that would bring the number of residents below the required critical mass of three residents per year for 2 consecutive years.

2. The program director must obtain prior approval for the following changes in the program in order

for the RRC to determine if an adequate educational environment exists to support these changes:

a. The addition of any participating institution to which residents rotate for 6 months full-time equivalent (FTE) or longer

b. The addition or deletion of any rotation of six months FTE or longer

c. Any change in the approved number of resident positions in the program

d. Any change in the total length of the program.

On review of such proposals or important changes in a program, the RRC may determine that a site visit is necessary.

D. Education Policy Committee

The director of the residency program should have an educational policy committee composed of members of the psychiatry program teaching staff that includes representation from the residents as well as a member of the teaching staff from each ACGME-approved subspecialty residency that may be affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. This committee should participate actively in

1. Planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee);
2. Determining curriculum goals and objectives; and
3. Evaluating both the teaching staff and the residents.

E. Number and Qualifications of the Faculty

All members of the teaching staff must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, support of the goals and objectives of the program, commitment to their own continuing medical education, and participation in scholarly activities.

1. There must be a sufficient number of teaching staff to instruct and supervise adequately all the residents in the program. Members of the teaching staff must be able to devote sufficient time to meet their supervisory and teaching responsibilities. The residency must be staffed by a sufficiently wide variety and appropriate number of capable psychiatrists and other mental health professionals with documented qualifications to achieve the goals and objectives of the training program.

2. The faculty psychiatrists should be certified by the American Board of Psychiatry and Neurology or have appropriate qualifications in psychiatry satisfactory to the RRC.

3. A written record of the educational responsibilities of all staff and faculty members (whether full-time or part-time) who participate directly in the education of residents is essential. That record should include the qualifications and experience of each faculty member and the nature, as well as the frequency, duration, and site, of the teaching activity.

4. There must be evidence of scholarly activity among the faculty psychiatrists. Scholarly activity is defined as professional activities that serve to enhance the profession or professional knowledge. While not all members of a faculty need be investigators, scholarly activities should be present on a continuous basis. There should also be evidence of participation in a spectrum of academic and professional activities within the institution as well as within local and national associations. Such evidence should include

   a. documentation of teaching excellence;

   b. participation in clinical and/or basic research;

   c. involvement in relevant medical scientific organizations and their meetings; and

   d. publications in refereed journals, monographs, and books.

5. The faculty must participate regularly and systematically in the training program and be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.

6. The faculty psychiatrists should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.

7. A member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.

8. The teaching staff must be organized and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.

9. The teaching staff should periodically evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of residents.

F. Other Program Personnel

Programs must be provided with the additional professional, technical, and clerical personnel needed to support the administration and educational conduct of the program.

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IV. Program Facilities and Resources

A. Clinical Facilities and Resources

1. All programs must have adequate patient populations for each mode of required training and, minimally, must include organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry.

2. Training programs must have available to them adequate inpatient and outpatient facilities and other suitable clinical placements where the residents can meet the educational objectives of the program. The program should specify the facilities in which the goals and objectives are to be implemented.

3. All residents must have available offices adequate in size and decor to allow them to interview patients and accomplish their duties in a professional manner. The facility also must provide adequate and specifically designated areas in which residents can perform basic physical examination and other necessary diagnostic procedures and treatment interventions.

B. Other Educational Resources

1. The administration of the facility where the program is located must provide ample space and equipment for educational activities. There must be adequate space and equipment specifically designated for seminars, lectures, and other teaching exercises.

2. The program must have available audiovisual equipment and teaching material such as films, audio cassettes, and videotapes, as well as the capability to record and play back educational videotapes.

3. Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions. Library services should include the electronic retrieval of information from medical databases.

4. There must be access to an on-site library and/or to an electronic collection of appropriate texts and journals. On-site libraries and/or collections of texts and journals must be readily available

during nights and weekends.

This library should provide

a. a substantial number of current basic textbooks in psychiatry, neurology and general medicine;

b. a number of the major journals in psychiatry, neurology, and medicine sufficient for an excellent educational program;

c. the capability to obtain textbooks and journals on loan from major medical libraries;

d. capability to perform MEDLINE or other medical information searches (or ready access to a library that has this capacity); and

e. access to the Internet.

5. Each clinical service must have a mechanism that ensures that charts are appropriately maintained and readily accessible for regular review for supervisory and educational purposes. Randomly selected charts will be reviewed at the time of survey.

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V. The Educational Program

The director and teaching staff of a program must prepare and comply with written educational goals for the program. All educational components of a residency program should be related to program goals. The program design and/or structure must be approved by the RRC for Psychiatry as part of the regular review process.

A. Objectives of Training

1. First Year

The training obtained during the first postgraduate year should provide residents with medical skills most relevant to psychiatric practice. These include being able to

a. perform a complete initial history and physical examination, including appropriate diagnostic studies;

b. diagnose common medical and surgical disorders and to formulate appropriate initial treatment plans;

c. provide limited, but appropriate, continuous care of patients with medical illnesses and to make appropriate referrals;

d. be especially conversant with medical disorders displaying symptoms likely to be regarded as psychiatric, and with psychiatric disorders displaying symptoms likely to be regarded as medical;

e. be especially cognizant of the nature of the interactions between psychiatric treatments and medical and surgical treatments; and

f. relate to patients and their families, as well as other members of the health care team with compassion, respect and professional integrity.

2. Second Through Fourth Years

The program must provide a well-planned, high-quality curriculum that includes specific, assessable objectives for program components as well as criteria for graduation. These must be in writing and provided to each resident and faculty member. Residents must be taught to conceptualize all illnesses in terms of biological, psychological, and sociocultural factors that

determine normal and abnormal behavior. They must be educated to gather and organize data, integrate these data within a comprehensive formulation of the problem to support a well-reasoned differential diagnosis, formulate a treatment plan, and implement treatment and follow-up care as required. The program must provide residents with sufficient opportunities to develop knowledge, clinical skills, sensitivity to cultural diversity, and professional principles.

a. The didactic curriculum should include

1. critical appraisals of the major theories and viewpoints in psychiatry, together with a thorough grounding in the generally accepted clinical facts;

2. presentation of the biological, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle;

3. presentation of the etiologies, prevalence, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, sociocultural, and iatrogenic factors that affect the long-term course and treatment of psychiatric disorders/conditions;

4. comprehension of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice such as neoplasms, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, Parkinson's disease, seizure disorders, stroke, intractable pain, and other related disorders;

5. the use, reliability, and validity of the generally accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing;

6. the financing and regulation of psychiatric practice, including information about the structure of public and private organizations that influence mental health care;

7. medical ethics as applied to psychiatric practice;

8. the history of psychiatry and its relationship to the evolution of medicine;

9. the legal aspects of psychiatric practice;

10. when and how to refer; and

11. research methods in the clinical and behavioral sciences related to psychiatry.

b. Clinical training should provide sufficient experiences in

1. the elements of clinical diagnosis with all age groups (of both sexes, to include some ethnic minorities), such as interviewing; clear and accurate history taking; physical, neurological, and mental status examination; and complete and systematic recording of findings;

2. relating history and clinical findings to the relevant biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment;

3. formulating a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, taking into consideration all relevant data;

4. the major types of therapy, including short- and long-term individual psychotherapy, psychodynamic psychotherapy, family/couples therapy, group therapy, cognitive and behavior therapy, crisis intervention, drug and alcohol detoxification, and pharmacological regimens, including concurrent use of medications and psychotherapy;

5. electroconvulsive therapy, a somatic therapy that is viewed as so important that its absence must be justified (Examples of other somatic therapies include biofeedback ar.d phototherapy.);

6. providing continuous care for a variety of patients from different age groups, seen regularly and frequently for an extended time, in a variety of treatment modalities;

7. psychiatric consultation in a variety of medical and surgical settings;

8. providing care and treatment for the chronically mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;

9. psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;

10. providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment;

11. knowledge of the indications for and limitations of the more common psychological and neuropsychological tests;

12. critically appraising the professional and scientific literature; and

13. teaching psychiatry to medical students, residents, and others in the health professions.

B. Curriculum

1. Clinical Experience

Carefully supervised clinical care of patients is the core of an adequate program. The clinical services must be so organized that residents have major responsibility for the care of a significant proportion of all patients assigned to them and have sufficient and ongoing high-quality supervision. The number of patients for which residents have primary responsibility at any one time must be adequate enough to permit them to provide each patient with appropriate treatment and to have sufficient time for other aspects of their educational program. At the same time, the total number must be large enough to provide an adequate depth and variety of clinical experiences. The amount and type of patient care responsibility a resident assumes must increase as the resident advances in training. Each resident must have major responsibility for the diagnosis and treatment of a reasonable number and adequate variety of patients with both acute and chronic illnesses representing the major psychotic and nonpsychotic categories of psychiatric diagnoses/conditions. Adequate experience in the diagnosis and management of the medical and neurological disorders encountered in psychiatric practice also must be ensured. Each resident must have supervised experience in the evaluation and treatment of patients of different ages throughout the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds. It is desirable that residents have didactic learning and supervised experiences in the delivery of psychiatric services in the public sector and in managed care health systems. The clinical experiences are to be designed to develop the requisite skills as outlined in Section V.A.2.b., above. Specific clinical experiences must include the following:

a. Neurology: Two months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. This 2-month experience (or its equivalent if done on a part-time basis) may occur in an inpatient, outpatient, or consultation/liaison setting. A maximum of one month of child neurology may be used toward the 2-month requirement. The 2-month training experience must provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment and/or evolution of their neurological disorders/conditions. The training in neurology should have sufficient didactic and clinical experience for residents to develop expertise in the diagnosis of those neurological disorders/conditions that might reasonably be expected to be encountered in psychiatric practice and that must be considered in the differential diagnosis of psychiatric disorders/conditions.

b. Inpatient: Significant responsibility for the assessment, diagnosis, and treatment of an appropriate number and variety of general psychiatric inpatients for a period of not less than 9 months, but no more than 18 months (or its full-time equivalent if done on a part-time basis). In general, it is highly desirable that the minimum general inpatient experience be 12 months, although it is recognized that in some settings other training opportunities might lead to the absolute minimum of 9 months. The experience must provide residents with sufficient opportunities to develop competence in the intensive biopsychosocial assessment and management of patients with acute mental disorders/conditions. It is recognized that

the setting in which this care occurs may vary according to the health care delivery system. Rotations on specialized clinical services such as addiction psychiatry, adolescent psychiatry, forensic psychiatry, geriatric psychiatry, research units, and day and/or partial hospitalization may not totally substitute for the general psychiatric inpatient experience. These may be included to meet the required minimum experiences, with adequate documentation to demonstrate that the experience on such specialized units is with acutely ill patients and is comparable in breadth, depth, and experience to training on general inpatient psychiatry units. Up to 3 months of rotations on specialized clinical services as noted above may be applied to the minimum 9-month requirement. However, no portion of this experience may be counted to meet the timed requirement in child and adolescent psychiatry. Experience in any special unit used to provide inpatient psychiatry must be under the direction and supervision of a psychiatrist.

c. Outpatient: An organized, continuous, supervised clinical experience in the assessment, diagnosis, and treatment of outpatients of at least 1 year (or its full-time equivalent if done on a part-time basis) that emphasizes a developmental and biopsychosocial approach to outpatient treatment. At least 90% of this experience must be with adult patients. A minimum of 20% of the overall experience (clinical time and patient volume) must be continuous and followed for a duration of at least 1 year. The outpatient requirement must include experience with a wide variety of disorders, patients, and treatment modalities, with experience in both brief and long-term care of patients, using individual psychotherapy (including psychodynamic, cognitive, behavioral, supportive, brief), and biological treatments and psychosocial rehabilitation approaches to outpatient treatment. Long-term psychotherapy experience must include a sufficient number of patients, seen at least weekly for at least 1 year, under supervision. Other long-term treatment experiences should include patients with differing disorders and patients who are chronically mentally ill. No portion of this experience may be counted to meet the timed requirements in child and adolescent psychiatry.

d. Child and Adolescent Psychiatry: An organized clinical experience under the supervision of child and adolescent psychiatrists in the evaluation, diagnosis, and treatment of children, adolescents, and their families. Such experiences should be no less than 2 months full-time equivalent and involve a sufficient number and variety of patients, by both age and psychopathology, treated with a variety of interventional modalities. Residents should have experiences in determining the developmental status and needs for intervention with the children of some of their adult patients, and in consulting with these patients regarding the referral of their children for psychiatric services. Residents must have patient care responsibility under the supervision of child and adolescent psychiatrists who are certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or who possess appropriate educational qualifications. This 2-month experience may be provided in a variety of settings (eg, outpatient). While adolescent inpatient units may be used to satisfy a portion of this requirement, rotations to student health services may not.

e. Consultation/Liaison: Supervised psychiatric consultation/liaison responsibility for a minimum of 2 months full-time equivalent, involving adult patients on other medical and surgical services. On-call experiences may be a part of this training. Up to 1 month of pediatric consultation/liaison psychiatry may be credited toward the 2-month requirement.

f. Emergency Psychiatry: Supervised responsibility on an organized, 24-hour psychiatric emergency service that is responsible for evaluation, crisis management, and triage of psychiatric patients. Instruction and experience should be provided in the evaluation and management of suicidal patients. A psychiatric emergency service that is a part of, or interfaces with, other medical emergency services is desirable because of the opportunities for collaboration and educational exchange with colleagues in other specialties. There must be organized instruction and supervised clinical opportunities available to residents in emergency psychiatry that lead to the development of knowledge and skills in the emergency evaluation, crisis management, and triage of patients. This should include the assessment and management of patients who are a danger to themselves or others, the evaluation and reduction of risk to care givers, and knowledge of relevant issues in forensic psychiatry. There should be sufficient continued contact with patients to enable the resident to evaluate the effectiveness of clinical interventions. While on-call experiences may be a part of this training, such experiences alone will not be sufficient to constitute adequate training in emergency psychiatry. A portion of this experience may occur in ambulatory urgent care settings but must be separate and distinct from the 12 months of training designated for the outpatient requirement.

g. Community Psychiatry: Supervised responsibility for the care of persistently chronically ill patients in the public sector, (eg, community mental health centers and public hospitals and agencies, or other community-based settings). Experiential settings may include residential treatment centers, community mental health agencies, vocational rehabilitation centers, and senior citizen agencies. Opportunities should exist to consult with, learn about, and use community resources and services in planning patient care and to work collaboratively with case managers, crisis teams, and other mental health professionals.

h. Geriatric Psychiatry: One-month FTE supervised clinical management of geriatric patients with a variety of psychiatric disorders, including familiarity with long-term care in a variety of settings. This may be fulfilled as part of the inpatient or outpatient requirement.

i. Addiction Psychiatry: One-month FTE supervised evaluation and clinical management of patients with in inpatient and/or outpatient settings, and familiarity with rehabilitation and self-help groups. This may be fulfilled as part of the inpatient or outpatient requirement.

j. Forensic Psychiatry: Experience under the supervision of a psychiatrist in evaluation of patients with forensic problems.

k. Supervised clinical experience in the evaluation and treatment of couples, families, and groups.

l. Psychological Testing: Supervised experience with the more common psychological test procedures, including neuropsychological assessment, in a sufficient number of cases to give the resident an understanding of the clinical usefulness of these procedures and of the correlation of psychological test findings with clinical data. Under the supervision and guidance of a qualified clinical psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, and some of this experience should be with their own patients.

m. Supervised, active collaboration with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients.

2. Didactic Components

The didactic and clinical curriculum must be of sufficient breadth and depth to provide residents with a thorough, well-balanced presentation of the generally accepted theories, schools of thought, and major diagnostic and therapeutic procedures in the field of psychiatry.

a. The curriculum must include a significant number of interdisciplinary clinical conferences and didactic seminars for residents in which psychiatric faculty members collaborate with neurologists, internists, and colleagues from other medical specialties and mental health disciplines.

b. Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include prepared lectures, seminars, and assigned readings that are carried out on a regularly scheduled basis. In a progressive fashion, it should expose residents to topics appropriate to their level of training as outlined in Section V.A.2. Staff meetings, clinical case conferences, journal clubs, and lectures by visiting professors are desirable adjuncts, but must not be used as substitutes for an organized didactic curriculum.

c. The curriculum must include adequate and systematic instruction in neurobiology; psychopharmacology, and other clinical sciences relevant to psychiatry, child and adult development; major psychological theories, including learning theory and psychodynamic theory and appropriate material from the sociocultural and behavioral sciences such as sociology and anthropology. The curriculum should address development, psychopathology, and topics relevant to treatment modalities employed with patients with severe psychiatric disorders/conditions.

d. The residency program should provide its residents with instruction about American culture and subcultures, particularly those found in the patient community associated with the training program. This instruction should include such issues as gender, race, ethnicity, socioeconomic status, religion/spirituality, and sexual orientation. Many physicians may not be sufficiently familiar with attitudes, values, and social norms prevalent among various groups of contemporary Americans. Therefore, the curriculum should contain enough instruction about these issues to enable residents to render competent care to patients from various cultural and ethnic backgrounds. Understanding cultural diversity is an essential characteristic of good clinical care. The program must devote sufficient didactic training to residents whose cultural backgrounds are different from those of their patients and provide a suitable educational program for them.

e. Didactic exercises must include resident presentation and discussion of clinical case material at conferences attended by faculty and fellow residents. This training should

involve experiences in integrative case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases presented.

3. Supervision

Clinical training must include adequate, regularly scheduled, individual supervision. Each resident must have at least 2 hours of individual supervision weekly, in addition to teaching conferences and rounds except when on non-psychiatric rotations. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.

4. Clinical Records

Clinical records must reflect the residents' ability to

a. record an adequate history and perform mental status, physical, and neurological examinations;

b. organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;

c. proceed with appropriate laboratory and other diagnostic procedures;

d. develop and implement an appropriate treatment plan followed by regular and relevant progress notes; and

e. prepare an adequate discharge summary and plan.

C. Resident Policies

1. The program should not allow on-call schedules and activities outside the residency that interfere with education, clinical performance, or clinical patient care responsibilities. The program should ensure

a. one day out of 7 free of program duties;

b. on average, on-call duty no more than every fourth night while on psychiatric services; and

c. adequate backup if patient care needs create resident fatigue sufficient to jeopardize patient care or resident welfare during or following on-call periods.

2. Each resident must be given a copy of the Essentials of Accredited Residencies at the beginning of training.

3. Readily available procedures for assisting the resident to obtain appropriate help for significant personal or professional problems should be in place.

D. Other Required Components

1. Scholarly Activity of the Residents and Faculty

Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility. The following components of a scholarly environment should be present:

a. The program must promote an atmosphere of scholarly inquiry, including the provision of access to ongoing research activity in psychiatry. Residents must be taught the design and interpretation of research studies, including the responsible use of informed consent, research methodology, and interpretation of data. The program must teach expertise in the critical assessment of new therapies and developments that are described in the literature. Residents must be advised and supervised by faculty members qualified in the conduct of research. Programs must have a plan to foster the development of skills for residents who are interested in conducting psychiatric research. This plan should include opportunities for

conducting research under the supervision of a mentor and training in the principles and methods of research.

b. Active participation of the teaching staff in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.

c. Participation in journal clubs and research conferences.

d. Active participation in regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publications in their journals.

e. Participation in research, particularly in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings.

f. Offering of guidance and technical support (eg, research design, statistical analysis) for residents involved in research.

g. Provision of support for resident participation in scholarly activities.

2. Progressive Responsibility

Under supervision, resident clinical experience in patient management should demonstrate graduated and progressive responsibility.

3. Teaching Opportunities

Residents must be instructed in appropriate methods of teaching and have ample opportunity to teach students in the health professions.

4. Electives

All programs should provide residents an opportunity to pursue individually chosen electives.

5. Record of Clinical Experience

There must be a record maintained of specific cases treated by residents, in a manner that does not identify patients but that illustrates each resident's clinical experience in the program. This record must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the case of transferring residents, the records should include the experiences in the prior as well as the current program. This record must be reviewed periodically with the program director or a designee and be made available to the surveyor of the program.

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VI. Internal Evaluation

The educational effectiveness of the entire program must be evaluated in a systematic manner by the residents and the faculty. In particular, the quality of the curriculum and the extent to which the educational goals have been met by residents must be assessed. Confidential written evaluations by residents should be utilized in this process. The results of these evaluations must be kept on file.

A. Evaluation of Residents

All programs should state specifically and as clearly as possible the objectives and competencies required for successful completion of the program. These objectives and criteria should be made available to residency applicants.

1. Regular, systematic, documented evaluation of the knowledge, skills, and professional growth of each resident, using appropriate criteria and procedures, must be maintained, including complete

records of evaluations containing explicit statements on the resident's progress toward meeting educational objectives and his/her major strengths and weaknesses. Each evaluation should be communicated to the resident in an ongoing and timely manner.

2. The program must provide opportunity for and document regularly scheduled meetings between the resident and the program director or designated faculty members. These meetings should be of sufficient frequency, length and depth to ensure that the residents are continually aware of the quality of their progress toward attainment of professional goals and objectives. These evaluation sessions should be held at least semiannually and preferably more frequently. The program should give residents opportunities to assess the program and the faculty in a manner that ensures resident confidentiality. Provision should be made for remediation in cases of unsatisfactory performance.

3. The program must formally examine the cognitive knowledge of each resident at least annually in the PG-2 through PG-4 years, and conduct an organized examination of clinical skills at least twice during the 4 years of training. In a timely manner, the program must develop specific remedial plans for residents who do not perform satisfactorily. Residents must not advance to the next year of training, or graduate from the program, unless the outcome from the remedial plan results in the attainment of educational and clinical goals established for the program.

4. Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional, educational, and clinical growth.

5. A written set of due-process procedures must be in place for resolving problems that occur when a resident's performance fails to meet required standards. These procedures must conform to those policies and procedures adopted by the sponsoring institution for the provision of due process to all residents training in sponsored programs, and must include the criteria for any adverse action, such as placing a resident on probation, or for terminating a resident whose performance is unsatisfactory. The procedures should be fair to the residents, to patients under their care, and to the training program. A copy should be provided to the residents at the beginning of training.

6. Upon any resident's departure from a program (including by graduation), the program director must prepare a letter describing the nature and length of the rotations for which the resident has been given credit. If a resident departs the program without receiving full credit for all educational experiences, the reasons for withholding credit must be specified in the letter. The resident must be given the letter, and a copy must be retained in the resident's permanent file.

7. When a resident leaves the program (including by graduation), the program director will affirm in the training record that there is no documented evidence of unethical or unprofessional behavior, nor any serious question regarding clinical competence. Where there is such evidence, it will be comprehensively recorded, along with the responses of the trainee. The evaluation should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.

8. For residents transferring to child and adolescent psychiatry, it is essential that the program director document the nature and length of the rotations for which the resident has been given credit and include a listing of any remaining requirements needed to successfully complete the general psychiatry program. The resident must be informed that eligibility for certification by the American Board of Psychiatry and Neurology is not possible unless all general psychiatry program requirements are met, even if the resident completes the requirements for training in child and adolescent psychiatry. A copy of this notification must be provided to the resident and a copy included in the resident's permanent file.

B. Evaluation of Resident Competencies

The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing assessment results to improve resident performance.

1. This plan should include use of dependable measures to assess residents' competence in

   a. patient care

   b. medical knowledge

   c. practice-based learning and improvement

d. interpersonal and communication skills

e. professionalism, and

f. systems-based practice

2. The program must demonstrate that residents have achieved competency in at least the following forms of treatment:

a. brief therapy

b. cognitive-behavioral therapy

c. combined psychotherapy and psychopharmacology

d. psychodynamic therapy, and

e. supportive therapy

3. A mechanism must be in place for providing regular and timely performance feedback to residents which utilizes assessment results to achieve progressive improvements in the performance of residents in each competency area.

4. Programs that do not have a set of measures in place must develop a plan for improving their evaluations or demonstrate progress in implementing such a plan.

5. The program must provide documented evidence to demonstrate that the proficiency/competence of each resident is assessed using techniques that may include supervisory reports, videotapes, oral examinations, case reports, patient care observations, or other methods.

C. Program Evaluation

1. Performance and outcome assessment results should be used to evaluate the educational effectiveness of the residency program.

2. Participation in and performance of graduates on examinations for certification by the American Board of Psychiatry and Neurology may be one measure of the quality of a program used by the Residency Review Committee in its evaluation of each program. Therefore, it is highly desirable that programs use such information as one measure of their quality control.

3. Programs must demonstrate that they have an ongoing mechanism to evaluate the effectiveness of their didactic and clinical teaching.

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VII. Inquiries Concerning Accreditation and Certification

A. All inquiries concerning the accreditation of psychiatry residencies should be addressed to Executive Director, Residency Review Committee for Psychiatry, 515 N State St / Ste 2000, Chicago, IL 60610.

B. All inquiries as to whether a physician is qualified to be admitted for examination for certification in psychiatry should be addressed to Executive Vice President, American Board of Psychiatry and Neurology, 500 Lake Cook Rd / Ste 335, Deerfield, IL 60015.

[1] Programs seeking interim approval of a permanent increase in the number of approved resident positions should contact the Executive Director of the RRC

ACGME Program Requirements

ACGME: September 2000 Effective: January 2001